KEVIN K. LEE, DDS
DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY
PERIODONTICS AND IMPLANTS

*PLEASE PRINT CLEARLY Date_____

PATIENT INFORMATION ☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Patient Name: First _____ M.I. _____ Last _____ Nickname _____

Sex: ☐Male ☐Female Date of Birth _____ Age _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Soc. Sec. # _____ - _____ - _____ Driver's License # _____ State _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home (_____)_____ - _____ Work (_____)_____ - _____ Cell (_____)_____ - _____

E-mail Address _____

By providing your e-mail address you agree to receive (*check one or both):* ☐ Appointment Reminders ☐ Practice Information

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

Employer _____Occupation _____ Phone (_____)_____-_____

Address: Street _____ City _____ State _____ Zip _____

Is the patient a minor? ☐Yes ☐No Student: ☐Full Time ☐Part Time ☐Not Name of School: _____

If patient is a minor, primary residency: ☐Both Parents ☐Mom ☐Dad ☐Step Parent ☐Shared Custody ☐Guardian

RESPONSIBLE PARTY ☐Self ☐Spouse ☐Parent ☐Other _____

Name of Responsible Party: First_____ Last_____

Date of Birth _____ Social Security Number _____ - _____ - _____

Address (*if different from patient*): Street _____ City _____ State _____ Zip _____

Phone: Home (_____)_____-_____ Work (_____)_____-_____ Cell (_____)_____-_____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Phone: Home (_____)_____-_____ Cell (_____)_____-_____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Patient Relationship to Insured _____

Sex: ☐Male ☐Female Date of Birth _____ Social Security Number _____ - _____ - _____

Address (*if different from patient*): Street _____ City _____ State _____ Zip _____

Employer _____Occupation _____ Phone (_____)_____-_____

Bus. Address: Street _____ City _____ State _____ Zip _____

Insurance Company Name _____ ☐PPO ☐ HMO

Ins. Address: Street _____ City _____ State _____ Zip _____

I.D.Number _____ Policy/Group Number _____ Group Name _____

SECONDARY INSURANCE INFORMATION (Complete this section if patient is covered by another insurance company)

Name of Insured:_____ Patient Relationship to Insured: _____

Sex: ☐Male ☐Female Date of Birth _____ Social Security Number _____ - _____ - _____

Address (*if different from patient*): Street _____ City _____ State _____ Zip _____

Employer _____Occupation _____ Phone (_____)_____-_____

Bus. Address: Street _____ City _____ State _____ Zip _____

Insurance Company Name _____ ☐PPO ☐ HMO

Ins. Address: Street _____ City _____ State _____ Zip _____

I.D.Number _____ Policy/Group Number _____ Group Name _____

REFERRAL INFORMATION (Whom may we thank for referring you?)

☐Doctor's Name _____

☐Advertisement _____ ☐Local Dental Society_____

☐One of our valued patients (name of patient) _____

☐Our Web Site ☐ Insurance Company ☐Other_____

Please list other members of your immediate family who are patients in our practice:

_____ _____ _____ _____

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS, CHECK YES OR NO AND FILL IN BLANK SPACES WHERE INDICATED. ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

Height _____ **Weight** _____

Are you in good health? ☐YES ☐NO Your last physical was on _____ (date)

Are you now under the care of a physican? ☐YES ☐NO Premedication: ☐YES ☐NO

Physician's Name _____ Phone (_____)_____-_____

Have you had any illness, operation, or been hospitalized? ☐YES ☐NO

If yes, what was the problem and when?_____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures:

Heart Condition

High Blood Pressure	☐YES	☐NO
Low Blood Pressure	☐YES	☐NO
Angina/Chest Pain	☐YES	☐NO
Fainting	☐YES	☐NO
Irregular Heart Beat	☐YES	☐NO
Heart Attack	☐YES	☐NO
If yes, when _____ (date)		
Heart Mumur	☐YES	☐NO
Heart Bypass	☐YES	☐NO
Heart Pacemaker	☐YES	☐NO
Stroke	☐YES	☐NO
Rheumatic Fever	☐YES	☐NO
Heart Valve Damage	☐YES	☐NO
Mitral Valve Prolapse	☐YES	☐NO

Liver Disease

Hepatitis	☐YES	☐NO
If yes, (circle one)	A B C	
Jaundice/ Liver Disease	☐YES	☐NO

Breathing/ Lung Condition

Asthma	☐YES	☐NO
Emphysema	☐YES	☐NO
Breathing Difficulties	☐YES	☐NO
Bronchitis/Chronic Cough	☐YES	☐NO
Tuberculosis	☐YES	☐NO
Snoring/Sleep Apnea	☐YES	☐NO
Sinus Problems	☐YES	☐NO

Joint Condition

Clicking/Pain in Jaw Joints	☐YES	☐NO
Arthritis	☐YES	☐NO
Artificial Joint Replacement	☐YES	☐NO
Swollen Ankles	☐YES	☐NO

Tumor/ Growth

Location _____		
Tumor/growth cancerous?	☐YES	☐NO
Radiation Treatment	☐YES	☐NO
Chemotherapy	☐YES	☐NO
Surgery	☐YES	☐NO

Immunosuppressed/ Blood Disease

HIV Positive	☐YES	☐NO
AIDS	☐YES	☐NO
Sexually Transmitted Disease	☐YES	☐NO
Abnormal Bleeding (From Extractions, Surgery, or Trauma)	☐YES	☐NO
Bruise Easily	☐YES	☐NO
Blood Transfusion	☐YES	☐NO
If yes, explain circumstances_____		
Blood Disorder	☐YES	☐NO
Infectious Mononucleosis	☐YES	☐NO
Anemia	☐YES	☐NO
Delay in Healing	☐YES	☐NO

Organ Condition/ Disease

Pancreas/Diabetes	☐YES	☐NO
Kidney	☐YES	☐NO
If yes, are you on dialysis?	☐YES	☐NO
Eyes/Glaucoma	☐YES	☐NO
Thyroid	☐YES	☐NO
Neurologic/ Epilepsy	☐YES	☐NO
Stomach/ Ulcers	☐YES	☐NO

Drug, Alcohol, Smoking

History of Drug Abuse	☐YES	☐NO
History of Alcohol Abuse	☐YES	☐NO
Smoker	☐YES	☐NO
If yes, specify amount _____		
Use of Chewing Tobacco	☐YES	☐NO

Other

Mental Health Problems	☐YES	☐NO
Malignant Hyperthermia	☐YES	☐NO
Other conditions in your mouth or lips	☐YES	☐NO
If yes, explain _____		
Any disease, serious illness/surgery condition problem not listed above?	☐YES	☐NO
If yes, explain _____		
Any adverse reaction associated with previous dental/medical treatment?	☐YES	☐NO
If yes, explain _____		

MEDICATION AND ALLERGIES

Please list all medication(s) you are taking (including natural, herbal, or homeopathic products):

Are you taking any of the following:

Antibiotics or Sulfa Drugs	☐YES	☐NO	Digitalis/Drugs for Heart Problems	☐YES	☐NO
Anticoagulants (Blood Thinners)	☐YES	☐NO	Nitroglycerin	☐YES	☐NO
High Blood Pressure Medications	☐YES	☐NO	Antidepressants	☐YES	☐NO
Cortisone (Steroids)	☐YES	☐NO	Muscle Relaxers	☐YES	☐NO
Tranquilizers	☐YES	☐NO	Stimulants	☐YES	☐NO
Pain Killers	☐YES	☐NO	Insulin, Tolbutamide	☐YES	☐NO

Have you been on any IV Bisphosphonates, i.e., *Zometa* , or Oral Bisphosphonates, i.e., *Foxamax* or *Actonel* , etc for chemotherapy or osteoporosis? ☐YES ☐NO

If yes, explain _____

Are you allergic to or had a reaction to any of the following:

Penicillin	☐YES	☐NO	Sulfa drugs	☐YES	☐NO
Valium or Other Tranquilizers	☐YES	☐NO	Barbiturates, Codeine or Other Narcotics	☐YES	☐NO
Latex	☐YES	☐NO	Sulfites	☐YES	☐NO
Aspirin	☐YES	☐NO	Iodine	☐YES	☐NO
Local Anesthetic (Numbing Med)	☐YES	☐NO	Sodium Pentothal	☐YES	☐NO

Please list any other medicaton or antibiotic you are allergic to:	**Please list any allergies other than drug allergies:**

Women Only (*Note: Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control*)

Is there a possibility of pregnancy?	☐YES	☐NO	Expected delivery date:_____		
Are you nursing?	☐YES	☐NO	Are you taking birth control pills?	☐YES	☐NO

OFFICE POLICY

Patient Responsibilities: We are committed to provide you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling reponsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the intial visit and a financial agreement is completed in advance of performing any treatment with our practice.

** Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans:Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS/ IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's protion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

****Please note: Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your reponsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. In the event of default, you will be responsible for all reasonable collection costs, attorneys fees, and court costs.***

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee or deposit to reserve the appointment time again, may be required. To service all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee or deposit to reserve the appointment time again, may be required.

AUTHORIZATIONS

INITIALS

*I certify that I have read and I understand this form. To the best of my knowledge, I have answered every question completely and accurately. I have advised the doctor of all medical problems of which I am aware. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member for his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

*I authorize this dental team to perform any necessary dental services that I may need and have consent to during diagnosis and treatment.

*I have read the above and agree to the financial and scheduling terms.

*I authorize the release of information necessary to process my dental benefit claims. I hearby authorize payment directly to this doctor named of the benefits otherwise payable to me.

*I hereby ackowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice of Privacy Practice.

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Signature of Patient (*Parent or Guardian if minor*): **X** **Date:** **X**

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obatined because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify): _____

I have reviewed the Patient's health history form above.

Signature of Doctor: **X** **Date:** **X**